Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: The Arc in Hawaii – Lusitana D	**CHAPTER 89**
Address: **1660 D Lusitana Street, Honolulu, Hawaii 96813**	**Inspection Date: November 21, 2019 Annual**

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-89-16 Admission policies. (b)(2) The caregiver shall coordinate with the division for screening, placement, and case management prior to admission. All individual plans shall be monitored and revised at least annually and as necessary by the case manager. **FINDINGS** Resident #1 – complete current individualized service plan dated 8/27/2019 was not on file.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The Service Supervisor requested a current ISP from the DOH Case Manager. Per the Case Manager, she has not completed the ISP however would do so and send it to the Service Supervisor within a week.	12/5/19

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☒	§11-89-16 Admission policies. (b)(2) The caregiver shall coordinate with the division for screening, placement, and case management prior to admission. All individual plans shall be monitored and revised at least annually and as necessary by the case manager. **FINDINGS** Resident #1 – complete current individualized service plan dated 8/27/2019 was not on file.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** The Service Supervisor will request for a current ISP 30 days after the ISP meeting is held (per Waiver standards). A written request will be submitted followed by phone calls at least once a month until the updated ISP is sent. The DOH unit supervisor will be contacted after 3 failed attempts to receive the information. Documentation will be kept in the resident's file.	12/5/16

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-89-18 Records and reports. (b)(1) During residence, records shall be maintained by the caregiver and shall include the following information: Copies of physician's initial, annual and other periodic examinations, evaluations, medical progress notes, relevant laboratory reports, and a report of re-examination of tuberculosis; **FINDINGS** Resident #1 – the caregiver noted the resident sees a foot specialist every month. But no records from the physician's office visits were on file.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** No notes from the podiatrist are available. The home manager contacted the physician who reported that he does not document visits that involve nail trimming. Upon the request of the home manager, the physician will complete the agencies consult form going forward. In addition, the home manager spoke with the guardian who accompanies the resident to their appointments and requested they give the consult forms to the physician during every visit.	12/5/19

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-89-18 Records and reports. (b)(1) During residence, records shall be maintained by the caregiver and shall include the following information: Copies of physician's initial, annual and other periodic examinations, evaluations, medical progress notes, relevant laboratory reports, and a report of re-examination of tuberculosis; **FINDINGS** Resident #1 – the physician's note stated MRI was scheduled on 5/14/2019. No result on file.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** A copy of MRI results were obtained and filed. See attachment 1.	12/2/19

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-89-18 Records and reports. (c) Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be submitted to the case manager within twenty-four hours from the time of the incident and shall be retained by the facility under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician shall be called immediately if medical care is necessary. **FINDINGS** Resident #1 – the caregiver noted the office visits 1/17/2019 and 1/22/2019 for influenza infection in progress notes. But incident reports were not generated.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

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☒	§11-89-18 Records and reports. (e)(5) General rules regarding records: All records shall be complete and current and readily available for review by the department or any responsible placement agency. **FINDINGS** Resident #1 – current medication list in personal information form were not up to date.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Face sheet was updated with current medication list in the home.	12/3/19

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Licensee's/Administrator's Signature: Christine Menezes

Print Name: Christine Menezes, Director of Programs & Services

Date: November 6, 2019